AN ANALYSIS OF
THE MANAGED COMPETITION ACT

The Congress of the United States
Congressional Budget Office

NOTES

Numbers in the text and tables of this report may not add to totals because of rounding.

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Preface

The Congressional Budget Office (CBO) has prepared this analysis of the Managed Competition Act of 1993 in response to several Congressional requests. The report summarizes the main provisions of the proposal, examines how they relate to the key features necessary to achieve the full potential of the managed competition approach, and estimates the proposal's effects on national health expenditures and the federal budget. The report also examines the proposal's impact on the economy and other considerations affecting its design and implementation.

Many staff members in several of CBO's divisions contributed to the analysis contained in this report. Paul Van de Water coordinated the analysis and the preparation of the report. Linda Bilheimer was responsible for the Summary and Chapter 5, Paul Van de Water for Chapters 1 and 3, Leonard Burman and Sandra Christensen for Chapter 2, and Douglas Hamilton for Chapter 4.

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Summary

The Managed Competition Act of 1993 endeavors to slow the growth of health care costs and expand access to health insurance by strengthening competitive forces in health care markets and providing people with better access to affordable coverage. It would restructure health insurance markets, provide people with strong incentives to purchase health insurance prudently, and subsidize health insurance for low-income people.

The proposal would make health insurance available to all but would not establish universal coverage. Individuals would not have to obtain coverage if they did not choose to do so, and employers would only have to offer--not pay for--coverage for their workers. Even without individual or employer mandates, the number of uninsured people would drop significantly under the proposal.

The major vehicle for reorganizing the health care marketplace would be regional health plan purchasing cooperatives (HPPCs). Through them, employees of small firms (generally those with 100 or fewer employees) and individuals with no attachment to the labor force would purchase coverage. (Medicare's coverage would, however, be essentially unchanged.) The HPPC would offer those people a choice of accountable health plans (AHPs), which would provide a standard benefit package. AHPs would have to meet strict requirements regarding open enrollment, limits on exclusions for preexisting conditions, and modified community rating--allowing each AHP's premiums to vary only by age and the type of enrollment (individual, individual and spouse, individual and one child, and individual and family).

Firms with more than 100 employees would also have to offer their employees the opportunity to purchase coverage from an AHP. They could accomplish this either by self-insuring--that is, setting up their own AHPs--or by purchasing coverage from an AHP offered in the non-HPPC marketplace. They could not participate in a HPPC, however, unless they were located in states that took advantage of the option to raise the maximum size of firms that must participate in a HPPC.

The proposal would make changes in the tax code, some of which would promote more widespread insurance coverage while others would discourage the purchase of generous policies. Premiums paid to AHPs would be tax deductible up to the "reference premium"--that is, the premium for the lowest-cost plan offered through the HPPC that covered at least a specified proportion of eligible enrollees. The deduction would encourage people to purchase health insurance: under current law, the self-employed and people purchasing individual policies generally do not qualify for tax subsidies. Because premiums in excess of the reference premium would not be deductible, employers would be encouraged to limit their contributions for health insurance premiums, and consumers motivated to select lower-cost health plans.

Under the proposal, the Medicaid program would end, and a broad system of federal subsidies would enable low-income people to purchase acute care coverage from AHPs. States would assume responsibility for the long-term care component of Medicaid, with most of them benefiting from the new division of responsibilities with the federal government.

Subsidies for premiums and cost sharing would be available for everyone with income below 200 percent of the poverty level. (The only exceptions would be Medicare beneficiaries for whom subsidies would mirror current Medicaid benefits for dually eligible enrollees and "qualified Medicare beneficiaries.") Those at or below 100 percent of the poverty level would be fully subsidized for the reference premium. The premium subsidies would be phased out between 100 percent and 200 percent of the poverty level. By contrast, the subsidies for cost sharing would be the same throughout the entire income range up to 200 percent of the poverty level; no one in this group would have to pay more than nominal cost-sharing amounts. Individuals with income below 100 percent of the poverty level would also be eligible to receive a package of wraparound benefits--additional benefits that would not be part of the standard benefit package.

Spending on the subsidies would be limited to the amounts generated by proposed reductions in current health care programs, revenue changes, and prefunding of retiree health benefits for the Postal Service. Low-income participants would not be required to pay more if insufficient funds were available to fund the subsidies fully; rather, AHPs would have to absorb the shortfalls.

A new federal agency, the Health Care Standards Commission, would oversee the health care system and design the uniform benefit package. It would establish broad principles and standards for the system and would also undertake such day-to-day activities as determining eligibility for subsidies and registering AHPs. The commission's responsibilities would be far-reaching and would generally transcend those of state and local governments in the health care arena.

Managed Competition

The managed competition approach, which provides the basis for this proposal, remains largely untried. Advocates of the approach believe it has the potential to slow the rate of growth of health spending, but estimates of the magnitude of such effects are highly speculative. When the Congressional Budget Office (CBO) examined this issue in a 1993 study, it concluded that the capacity of any particular managed competition proposal to control costs would depend on the degree to which it included the following eight features:

- o Regional purchasing cooperatives that would oversee a restructured health insurance market;
- o Universal access to health insurance with community rating of premiums and limited restrictions on coverage;
- o Universal health insurance coverage;
- o A standard package of benefits for all health plans;
- o Comparative information on the price and the quality of all health plans;
- o Health plans with almost no overlap in their networks of providers;
- o Effective mechanisms to adjust the premiums paid to health plans for the health risks of their enrollees; and
- o Limits on the amount of health insurance premiums that people could shelter from taxes set at the cost of the least expensive plan.

The Managed Competition Act includes all or part of seven of these features. It would not, however, require universal coverage, even though the number of uninsured people would certainly fall. Whether an effective risk-adjustment mechanism could be developed is uncertain, but that problem besets many health care proposals--not this one alone. The proposal would also be in closer accord with the eight conditions if all of the population had to purchase health insurance through HPPCs and if HPPCs were given more power to negotiate with health plans.

CBO believes that the proposal incorporates the key attributes of managed competition sufficiently well that--over time--significant savings would result from both the more competitive market environment and the enrollment of more people in effectively managed plans. The magnitude of these savings, however, remains largely a matter of speculation. Presumably, the effect on the growth rate of national health expenditures (NHE) would depend on the benefits included in the standard package. The more comprehensive the package, the larger the proportion of NHE that would be under the managed competition system and, hence, subject to its cost-reducing incentives. For the purpose of its cost estimates, CBO assumed that increasing enrollment in effectively managed plans would slow the growth in costs of AHPs by 0.6 percentage point per year for the first five years. In addition, competitive forces would dampen the rate of growth of costs of AHPs by increasing amounts over the projection period, thereby reducing the annual rate of growth by 1 percentage point after 2004.

Financial Impact of the Proposal

As with other proposals to restructure the health care system fundamentally, estimates of the effects of this proposal on national health expenditures and on the federal budget are highly uncertain. In addition to the lack of evidence about the effects of managed competition per se, the proposal leaves many important details--such as the standard benefit package--unspecified.

In preparing its cost estimates, therefore, CBO had to make a number of assumptions about the effectiveness of managed competition and the unspecified dimensions of the proposal. The estimates are extremely sensitive to these assumptions, the most important of which relate to the standard benefit package. In general, a more comprehensive benefit package would result in a higher premium, which would--in turn--translate into higher budgetary costs and national health expenditures. Although a more limited benefit package would have a lower premium, it would probably have little effect on the number of people with insurance. More limited standard benefits would, however, raise the after-tax costs of insurance for people who currently have more comprehensive policies, many of whom would probably purchase supplementary coverage out of after-tax income. As a result, they would probably become more prudent purchasers of health insurance.

Because of the uncertainty regarding the benefit package, CBO estimated the financial effects of the proposal under two illustrative alternatives. The first is the comprehensive benefit package proposed in the Administration's Health Security Act. The second is a benefit package costing 20 percent less than the first; it would have limited hospital coverage and would not cover prescription drugs, dental care, mental health, and preventive services. CBO concluded that, for differing reasons, neither alternative would be feasible without further adjustments to the proposal.

Under the more comprehensive alternative, the number of uninsured people would drop by almost 40 percent in 1996 (from 39 million to 24 million), with less than 10 percent of the population remaining uninsured thereafter. National health expenditures would rise above CBO's baseline initially--reflecting the increase in the number of people with insurance--but would fall below the baseline once the effects of managed competition, more enrollment in managed care, and cuts in the Medicare program began to be felt. By 2004, NHE would be $30 billion (or about 1½ percent) below the baseline.

Under this alternative, spending on subsidies would far exceed the funds designated for them; between 1996 and 2000, the average annual shortfall would be over 30 percent of the subsidies for premiums for non-Medicare enrollees. Although the proposal would require health plans to absorb shortfalls in subsidies, shortfalls of that magnitude could cause turmoil in HPPC markets. To avoid that possibility, the subsidies would have to be close to or fully funded. Consequently, some other features of the proposal would have to change if one wished to maintain a comprehensive benefit package. Possible options include reducing the generosity of the subsidies or augmenting the pool of resources available to fund the subsidies by cutting other programs, raising taxes, or allowing the budget deficit to increase.

Under the less comprehensive benefit package, the number of uninsured people would be about the same as under the first alternative. As before, national health expenditures would rise in the early years--but by less than under the comprehensive alternative--and then fall below CBO's baseline.

Even though the premium would be 20 percent lower under the second alternative, the resources available under the proposal would be insufficient to fund the premium subsidies fully. Rather than cut back the already Spartan benefit package further, CBO chose to modify the proposal's subsidy scheme to permit full funding of the subsidies without exceeding the funds available in the subsidy pool. For the purposes of this illustration, CBO assumed that the cost-sharing subsidies for people with income between 100 percent and 200 percent of the poverty level would be dropped. With that additional assumption, the subsidies would be funded in full or nearly so after 1997.

Effects of the Proposal on the Economy

By ensuring that people could purchase health insurance at community rates regardless of their health status, the proposed restructuring of the health insurance market would improve certain aspects of labor markets. For example, it would assure workers who have health insurance through their jobs that they could continue to obtain coverage if they changed jobs or left the labor force. Insofar as some workers hesitate to change jobs because of the possibility of losing their health insurance, the problem of "job lock" would be reduced. Moreover, some workers might choose to retire early if they knew they could still obtain health insurance.

The subsidies for premiums and cost sharing would greatly reduce the number of people without coverage and would be very beneficial for low-income workers. But such workers would receive the full benefit of the proposed subsidy system only if their employers did not pay for insurance and, consequently, low-income workers would have incentives to work for employers that did not pay for insurance. If the employer of a low-wage worker contributed some amount toward insurance coverage, the subsidy would be reduced dollar for dollar under the proposal. In addition, the worker's wage would be lower than it would be if the employer did not contribute because employers shift the costs of such contributions back onto workers through reduced cash wages.

These effects would be particularly pronounced for workers with employment-based insurance and income close to the poverty level; they could earn considerably more if their employers no longer paid for coverage and subsidies would pay for most of their health insurance. By contrast, higher-income workers, who would not be eligible for subsidies, would probably prefer that their employers pay for insurance rather than pay them higher cash wages in order to avoid the payroll taxes they would pay on higher wages.

A less desirable consequence of the proposed system of subsidies is that it could discourage some people with incomes between 100 percent and 200 percent of the poverty level from working more. People with income in the range in which the subsidies were phased out would have to pay more for health insurance as their income rose. Some workers in this income range already face high effective marginal tax rates because of the phaseout of the earned income tax credit and the payment of income and payroll taxes. The phaseout of the subsidies for premiums would impose an additional marginal levy on workers of 15 percentage points to 30 percentage points, depending on their family type and the comprehensiveness of the benefit package.

Low-income families would also lose valuable benefits abruptly if their income rose to the point at which they lost eligibility for cost-sharing subsidies. (That income level would be 200 percent of poverty under the proposal as written, or 100 percent of poverty under CBO's second alternative with limited benefits.) Since there would be no graduated phaseout of those subsidies, a large "cliff" effect would result: below the income cutoff, people would have full cost-sharing benefits--worth an average of approximately $1,400 for a family of four in 1995--and above that income level they would not have any. A similar "cliff" would occur when people's income reached 100 percent of the poverty level and they lost their eligibility for wrap-around benefits. The amount they would lose would depend on the benefits covered by the standard benefit package--the more generous the coverage the less would be included in the wraparound benefits. Thus, under the comprehensive benefit package, the wraparound benefits would be worth an average of $600 for a family of four in 1995; under the less generous alternative, they would be worth $2,900.

The problem of high effective marginal tax rates for people affected by the phaseout of subsidies is not unique to this proposal. Unfortunately, alternative solutions--such as reducing subsidies or phasing them out over a wider income range--would generate other problems. Smaller subsidies would require low-income people to pay a higher percentage of their health care costs; a slower phaseout would increase federal subsidy payments and cause workers at higher income levels to face disincentives for additional work.

How Shortfalls in Payments Would Affect AHPs and Insurance Markets

Certain features of the proposal might produce unintended consequences, lengthen the time needed for implementation, or limit the effectiveness of the proposal. Some of those features could be modified quite easily. Modifying others might prove more difficult.

One particularly problematic feature of the proposal is the large shortfalls that could face AHPs. If the funding designated for subsidies was insufficient to pay them in full, the federal government would reduce the proportion of the premium subsidies it paid and the AHPs would have to absorb the difference. They could not require low-income enrollees to pay more.

Shortfalls in premiums paid to health plans could also occur with full funding of the federal subsidies because the maximum federal subsidy could not exceed the reference premium for the HPPC. Low-income enrollees who chose AHPs with premiums higher than that amount would have to pay only a portion of the difference; the plans would have to absorb the shortfall. Some plans might also experience shortfalls in subsidies for cost sharing because those payments would not be related to the actual use of services by a plan's low-income enrollees.

To ensure that shortfalls in payments would not disproportionately affect AHPs enrolling large numbers of low-income people, the proposal would establish an interplan reconciliation process for low-income assistance. The scheme would require all AHPs, including self-insured plans, to participate in a nationwide system to distribute shortfalls in premiums and cost sharing equitably among health plans. This process would be extremely complicated; its feasibility is doubtful. Yet, without an effective mechanism, premiums in the HPPC could be highly unstable.

Instability of premiums would be a consequence of both the uncertainty plans would face in setting premiums and their probable responses to shortfalls. Although health plans could adapt to some uncertainties, as they do today, the proposed approach for shifting shortfalls in payments to plans would require them to deal concurrently with many unknown, interdependent variables in determining their premiums. As a result, the process would be exceptionally difficult. Moreover, there would be no guarantee that the uncertainties would lessen over time.

AHPs could respond to shortfalls in payments in various ways. But the responses and their impacts would generally be greater within HPPCs than outside them because low-income people would constitute a much higher proportion of the HPPC population. In the short term, AHPs might lower payments to providers or reduce the quantity or quality of the services they provided. In the longer term--when AHPs had the opportunity to do so--they would almost certainly raise their premiums. Plans facing strong competitive pressures might withdraw from the market altogether.

Because enrollment in AHPs would be voluntary, some people whose premiums were not heavily subsidized might drop their insurance coverage if premiums rose significantly. Healthy people who felt the least need for coverage would be the most likely to withdraw in those circumstances. The loss of healthier people would cause the average risk level of enrollees in the HPPC to rise, placing further upward pressure on premiums. An upward spiral of premiums in the HPPC might result.

In the absence of an effective distribution process, extremely high shortfalls in payments could rapidly undermine insurance markets. For example, under the comprehensive benefit package assumed in CBO's first alternative, the shortfalls in premium subsidies would be so large that the HPPC system might collapse if AHPs had to absorb them.

Conclusion

The Managed Competition Act would significantly reduce the number of people lacking health insurance, but--because key elements of the proposal are unspecified--its effects on the budget, the economy, and health insurance markets are uncertain. Although several features of the proposal as written might impair its effectiveness or prove difficult to implement, the majority of them could probably be addressed quite easily through minor modifications.

More controversial are those elements of the proposal that both reflect its underlying philosophy and might also limit its feasibility. For example, allowing enrollment in AHPs to be voluntary and restricting the size of firms that could participate in the HPPC would have the potential to produce unstable premiums--especially if the federal subsidies were not fully funded. Moreover, without additional revenues or spending cuts, deficit neutrality would be difficult to reconcile with a comprehensive benefit package and full funding of the subsidies.

Such problems present difficult choices and trade-offs. The most immediate question, however, concerns the issues that should be resolved now as part of the proposal versus those that should be left to the Health Care Standards Commission, other government agencies, or the Congress to decide in the future.